

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155780		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 08/26/2011	
NAME OF PROVIDER OR SUPPLIER  MADISON HEALTH CARE CENTER, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 7465 MADISON AVENUE INDIANAPOLIS, IN46227			
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K0000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 08/26/11</p> <p>Facility Number: 012225 Provider Number: 155780 AIM Number: 200983560</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Madison Health Care Center, LLC was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type III (200) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and all areas not separated from the corridor. The facility has a capacity of 130 and had a census of 64 at the time of</p>			K0000	<p><b>This plan of correction is to serve as Madison Health Care Center's credible allegation of compliance.</b></p> <p><b>Submission of this plan of correction does not constitute an admission by Madison Health Care Center or it's management company that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations.</b></p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K0029 SS=E	<p>this visit.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 09/01/11.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>1. Based on observation and interview, the facility failed to ensure 2 of 8 doors serving hazardous areas such as the mechanical room by the laundry and storage rooms greater than fifty square feet in size used to store combustible materials are each equipped with self closing devices on the entry door in order to automatically close and latch the door into the door frame. This deficient practice could affect any resident, staff or visitor in the vicinity the mechanical room</p>			K0029	<p>K029 – It is the practice of Madison Health Care Center to ensure that doors with self-closing devices are used to protect hazardous areas. I. a. The door to the mechanical room by laundry and the door to the central supply room were corrected by the maintenance supervisor. b. The trash cans that were greater than 32 gallons were removed from the building. II. All residents have the potential to be affected. This is being addressed by the systems</p>		09/25/2011

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	<p>by the laundry and the Central Supply room.</p> <p>Findings include:</p> <p>a. Based on observation with the Plant Operations Director during a tour of the facility from 12:15 p.m. to 2:55 p.m. on 08/26/11, the mechanical room by the laundry contains three natural gas fired water heaters and the entry door is not equipped with a self closing device. Based on interview at the time of observation, the Plant Operations Director acknowledged the mechanical room by the laundry is not equipped with a self closing device on the entry room door.</p> <p>b. Based on observation with the Plant Operations Director during a tour of the facility from 12:15 p.m. to 2:55 p.m. on 08/26/11, the Central Supply room measures 100 square feet and is used to store disposable briefs in cardboard boxes as well as other combustible nursing supplies and the entry room door is not equipped with a self closing device. Based on interview at the time of observation, the Plant Operations Director acknowledged the Central Supply room is greater than fifty square feet, is used to store combustible supplies, and is not equipped with a self closing device on the entry door.</p>				<p>described below. III. The maintenance supervisor will not purchase any trash containers that are greater than 32 gallons for future use in the facility. All self-closing doors will be inspected by the maintenance supervisor on a quarterly basis. IV. The self-closing doors will be added to the preventative maintenance program for re-inspection on a quarterly basis. The results of the audits are reported to the facility's quality assurance committee for additional recommendations as necessary.</p>		

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	3.1-19(b)  2. Based on observation and interview, the facility failed to ensure 1 of 1 areas where trash collection receptacles of greater than 32 gallons in any 64 square feet were being stored are in areas separated from other spaces by smoke resisting partitions and doors and in areas provided with an automatic extinguishing system. LSC 19.3.2.1 requires trash collection rooms to have self closing or automatic closing doors. This deficient practice could affect any resident, staff or visitor in the vicinity of the employee entrance corridor.  Findings include:  Based on observation with the Plant Operations Director during a tour of the facility from 12:15 p.m. to 2:55 p.m. on 08/26/11, two 16 cubic feet capacity (119.7 gallons per each cart) mobile trash carts were filled with combustible trash, were unattended and stored next to each other in the corridor by the employee entrance. The trash collection receptacles were not being stored in areas separated from other spaces by smoke resisting partitions and doors. Based on an interview at the time of observation, the Plant Operations Director stated the trash						

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K0045 SS=E	<p>carts were awaiting transport to the outside trash bin and acknowledged the employee entrance corridor was being used to store trash carts of greater than 32 gallon capacity.</p> <p>3.1-19(b)</p> <p>Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8</p> <p>Based on observation and interview, the facility failed to ensure the lighting for 1 of 8 exit means of egress was arranged so the failure of any single lighting fixture (bulb) would not leave the area in darkness. This deficient practice could affect any staff or visitor if needing to exit the facility from the employee exit.</p> <p>Findings include:</p> <p>Based on observation with the Plant Operations Director during a tour of the facility from 12:15 p.m. to 2:55 p.m. on 08/26/11, the exit means of egress from the employee exit is equipped with one light fixture with only one bulb. Based on interview at the time of observation, the Plant Operations Director acknowledged</p>		K0045	<p>K045 It is the practice of Madison Health Care Center to have illumination at means of egress that will not leave the area in darkness.I. The maintenance supervisor will replace the existing light fixture at the employee entrance so it will have two bulbs instead of one. II. All residents have the potential to be affected. This is being addressed by the systems described below. III. The maintenance supervisor will inspect all exit light fixtures on a quarterly basis for proper working order. IV. The affected area will be added to the preventative maintenance program for re-inspection on a quarterly basis. The results of the audits are reported to the facility's quality assurance committee for additional recommendations as</p>		09/25/2011	

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K0046 SS=C	<p>only one light fixture with one bulb was provided at the employee exit.</p> <p>3.1-19(b)</p> <p>Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.19.2.9.1.</p> <p>Based on observation, record review and interview; the facility failed to document testing of emergency lighting in accordance with LSC 7.9 for 2 of 2 battery operated emergency lights. LSC 7.9.3, Periodic Testing of Emergency Lighting Equipment, requires a functional test to be conducted at 30 day intervals and an annual test to be conducted on every required battery powered emergency lighting system for not less than 1 ½-hour duration. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all occupants in the facility including staff, visitors and residents.</p> <p>Findings include:</p> <p>Based on observations with the Plant</p>			K0046	<p>necessary.</p> <p>K046 It is the practice of Madison Health Care Center to do testing of the emergency lighting equipment. I. The facility has two battery operated emergency lights. The maintenance supervisor was unable to find documentation from the monthly or annual inspections. A monthly inspection will be completed by September 25 , 2011. II. All residents have the potential to be affected. This is being addressed by the systems described belowIII. The maintenance supervisor will perform a monthly and annual inspection of the battery operated emergency lights. IV. The affected area will be added to the preventative maintenance program for re-inspection on a monthly and annual basis. The results of the audits are reported to the facility's quality assurance committee for additional recommendations as necessary.</p>		09/25/2011

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	<p>Operations Director during a tour of the facility from 12:15 p.m. to 2:55 p.m. on 08/26/11, there are two battery operated emergency lights located in the facility. One battery operated light is located at the outside emergency generator and the second battery operated light is located at the emergency power transfer switch room inside the facility. Based on record review with the Plant Operations Director from 9:30 a.m. to 11:35 a.m. on 08/26/11, documentation of thirty day interval functional testing and annual testing for at least a 1 ½-hour duration for the two battery operated emergency lights was not available for review. Based on interview at the time of record review, the Plant Operations Director stated each battery operated emergency light is tested on a monthly basis but acknowledged there is no documentation available for review of thirty day interval or annual testing for each of the two battery operated emergency lights in the facility.</p> <p>3.1-19(b)</p>						

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K0050 SS=F	<p>Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>1. Based on record review and interview, the facility failed to conduct quarterly fire drills on the third shift for 1 of 4 quarters. This deficient practice affects all occupants in the facility including residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Record of Drills" documentation with the Plant Operations Director from 9:30 a.m. to 11:35 a.m. on 08/26/11, there is no documentation of a fire drill being conducted on the third shift for the fourth quarter of 2010. Based on interview at the time of record review, the Plant Operations Director acknowledged there was no documentation of a third shift fire drill in the fourth quarter of 2010 available for review.</p> <p>3.1-19(b)</p> <p>2. Based on record review and interview, the facility failed to document the</p>			K0050	<p>K050</p> <p>It is the practice of Madison Health Care Center to have fire drills at least quarterly on each shift and have transmission of the fire alarm signal.</p> <p>I. 1. The facility was in compliance with fire drill during the time frame cited. During this time frame the facility had 12 hour shifts so we only had two shifts per day instead of three. Three fire drills were performed in this quarter.</p> <p>2. The documentation of the fire alarm signal could not be found by maintenance supervisor.</p> <p>II. All residents have the potential to be affected. This is being addressed by the systems described below.</p> <p>III. The maintenance supervisor will continue to conduct fire drill quarterly on each shift. All fire drills will have documentation of the transmission of the fire alarm signal.</p> <p>IV. The fire drill audits are reported</p>		09/25/2011

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	<p>transmission of the fire alarm signal for 2 of 2 fire drills conducted prior to 9:00 p.m. on the first shift for 2 of 4 quarters and for 2 of 2 fire drills conducted prior to 9:00 p.m. on the second shift for 2 of 4 quarters. LSC 19.7.1.2 states fire drills in health care occupancies shall include the transmission of the fire alarm signal and simulation of emergency fire conditions. This deficient practice affects all occupants in the facility including residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Record of Drills" documentation with the Plant Operations Director from 9:30 a.m. to 11:35 a.m. on 08/26/11, documentation for two first shift fire drills conducted on 01/26/11 at 12:30 p.m. and on 04/27/11 at 10:40 a.m. and documentation for two second shift fire drills conducted on 02/28/11 at 3:47 p.m. and on 5/23/11 at 3:30 p.m. did not include the transmission of the fire alarm signal. Based on interview at the time of record review, the Plant Operations Director stated the fire alarm system was activated for each fire drill but acknowledged documentation of first and second shift fire drills conducted prior to 9:00 p.m. in the first and second quarter of 2011 did not include transmission of the fire alarm signal.</p>				to the facility's quality assurance committee monthly for additional recommendations and to ensure continued compliance.		

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K0051 SS=F	<p>3.1-19(b)</p> <p>A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station.</p> <p>19.3.4, 9.6</p> <p>Based on observation and interview, the facility failed to ensure the Digital Alarm Communicator Transmitter (DACT) telephone dialer(s) for the facility's fire alarm system would send a trouble signal within 4 minutes to a supervisory station and be annunciated locally when disabled. LSC Section 9.6.4 requires supervisor station notification to be in accordance with NFPA 72 National Fire Alarm Code. NFPA Section 5-5.3.2.1.6.1 states: A DACT shall employ one of the following combinations of transmission channels:</p> <p>(1) Two telephone lines (numbers)</p>			K0051	<p>K51</p> <p>It is the practice of Madison Health Care Center to have a digital alarm communicator transmitter (DACT) telephone dialers for the fire alarm system.</p> <p>I. An outside contractor came to the facility on 9-8-11 and repaired system so telephone lines report trouble.</p> <p>II. All residents have the potential to be affected. This is being addressed by the systems described below.</p> <p>III. During the monthly fire drills the maintenance supervisor will</p>		09/25/2011

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	<p>(2) One telephone line (number) and one cellular telephone connection</p> <p>(3) One telephone line (number) and a one-way radio system</p> <p>(4) One telephone line (number) equipped with a derived local channel</p> <p>(5) One telephone line (number) and a one-way private radio alarm system</p> <p>(6) One telephone line (number) and a private microwave radio system</p> <p>(7) One telephone line (number) and a two-way RF multiplex system</p> <p>(8) *A single integrated services digital network (ISDN) telephone line using a terminal adapter specifically listed for supervising station fire alarm service, where the path between the transmitter and the switched telephone network serving central office is monitored for integrity so that the occurrence of an adverse condition in the path shall be annunciated at the supervising station within 200 seconds.</p> <p>NFPA at 5-5.3.2.1.6.2 states the following requirements shall apply to all combinations in 5-5.3.2.1.6.1:</p> <p>(1) Both channels shall be supervised in a manner approved for the means of transmission employed.</p> <p>(2) Both channels shall be tested at intervals not exceeding 24 hours.</p> <p>Exception No. 1: For public cellular telephone service, a verification (test) signal shall be transmitted at least</p>				<p>ensure that the (DACT) telephone dialers for the facility's fire alarm system will send a trouble signal within 4 minutes to our supervisory station (SafeCare) and be annunciated locally when disabled.</p> <p>IV. The fire drill audits are reported to the facility's quality assurance committee monthly for additional recommendations and to ensure continued compliance.</p>		

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	<p>monthly.</p> <p>Exception No. 2: Where two telephone lines (numbers) are used, it shall be permitted to test each telephone line (number) at alternating 24-hour intervals.</p> <p>(3) The failure of either channel shall send a trouble signal on the other channel within 4 minutes.</p> <p>(4) When one transmission channel has failed, all status change signals shall be sent over the other channel.</p> <p>Exception: Where used in combination with a DACT, a derived local channel shall not be required to send status change signals other than those indicating that adverse conditions exist on the telephone line (number).</p> <p>(5) The primary channel shall be capable of delivering an indication to the DACT that the message has been received by the supervising station.</p> <p>(6) The first attempt to send a status change signal shall use the primary channel.</p> <p>Exception: Where the primary channel is known to have failed.</p> <p>(7) Simultaneous transmission over both channels shall be permitted.</p> <p>(8) Failure of telephone lines (numbers) or cellular service shall be annunciated locally.</p> <p>This deficient practice affects all residents, staff and visitors in the facility.</p>						

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K0075 SS=E	Findings include:  Based on observation with the Plant Operations Director during a tour of the facility from 2:10 p.m. to 2:20 p.m. on 08/26/11, when the DACT primary telephone line was disconnected from 2:10 p.m. to 2:20 p.m. the facility's fire alarm system failed to send a trouble signal to a supervisory station and failed to annunciate a trouble signal locally. Based on interview at the time of observation, the Plant Operations Director stated the facility's fire alarm system monitoring company did not receive a trouble signal when the DACT primary telephone line was disconnected and also acknowledged the fire alarm system failed to annunciate a trouble signal locally.  3.1-19(b)						
	Soiled linen or trash collection receptacles do not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space does not exceed .5 gal/sq ft (20.4 L/sq m). A capacity of 32 gal (121 L) is not exceeded within any 64 sq ft (5.9-sq m) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) are located in a room protected as a hazardous area when not attended. 19.7.5.5 Based on observation and interview, the facility failed to ensure a capacity of 32 gallons for mobile soiled linen or trash			K0075	K 075  It is the practice of Madison Health Care Center not to use trash or linen		09/25/2011

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K0144 SS=F	<p>collection receptacles was not exceeded within any 64 square feet area in 1 of 10 corridors. This deficient practice could affect any resident, staff or visitor in the vicinity of the employee entrance corridor.</p> <p>Findings include:</p> <p>Based on observation with the Plant Operations Director during a tour of the facility from 12:15 p.m. to 2:55 p.m. on 08/26/11, two 16 cubic feet capacity (119.7 gallons per each cart) mobile trash carts were filled with combustible trash, were unattended and stored next to each other in the corridor by the employee entrance. Based on an interview at the time of observation, the Plant Operations Director stated the trash carts were awaiting transport to the outside trash bin and acknowledged the employee entrance corridor was being used to store trash carts of greater than 32 gallon capacity.</p> <p>3.1-19(b)</p>				<p>containers greater than 32 gallons in any hazardous area when not attended.</p> <p>I. The two trash containers were removed from the facility.</p> <p>II. All residents have the potential to be affected. This is being addressed by the systems described below.</p> <p>III. The maintenance supervisor validated that no other containers in the facility are greater than 32 gallons. The administrator reviewed deficient practice with all administrative staff that would be responsibility for making future purchases of containers. The maintenance supervisor will perform a monthly hazard inspection of the facility.</p> <p>IV. The monthly hazard inspection will continue to be done monthly. The audits are reported to the facility's quality assurance committee monthly for additional recommendations and to ensure continued compliance.</p>		
	<p>Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>1. Based on observation and interview,</p>			K0144	K 144 It is the practice of Madison		09/25/2011

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	<p>the facility failed to ensure 1 of 1 emergency generators was equipped with a remote manual stop. NFPA 99, Health Care Facilities, 3-4.1.1.4 requires generator sets installed as alternate power sources shall meet the requirements of NFPA 110, Standard for Emergency Standby Power Systems. NFPA 110, 3-5.5.6 requires Level II installations shall have a remote manual stop station of a type similar to a break glass station located outside of the room where the prime mover is located. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Plant Operations Director during a tour of the facility from 12:15 p.m. to 2:55 p.m. on 08/26/11, no evidence of a remote shut off device was found for the 80 kilowatt natural gas fired emergency generator which had a manufacture date listed on the emergency generator label of October 2003. Based on interview at the time of observation, the Plant Operations Director acknowledged there is no remote emergency shut off for the emergency generator.</p> <p>3.1-19(b)</p>				<p>Health Care Center for the generator to operate in accordance with regulation. I. 1. The facility does not have a remote starter for the generator. A bid was obtained from an outside contractor to install a remote started. By 9-15-11 an approval will be received from corporate office for capital expenditure. The remote started will be installed by an outside contractor by 9-25-11. 2. The facility was able to find the written documentation of the weekly inspections of the starting batteries for the emergency generator. 3. The facility is unable to perform a monthly load test greater than 30%. To meet this requirement the facility has received a bid for an outside contractor to perform a load bank test. By 9-15-11 an approval will be received from corporate office for capital expenditure. The load bank test will be completed by an outside contractor by 9-25-11. II. All residents have the potential to be affected. This is being addressed by the systems described below. III. 1. The facility will have an outside contractor test the remote starter on an annual basis. 2. The facility will continue to perform weekly inspection of the starting batteries for the emergency generator. This will be added to the preventative maintenance program. 3. An outside contractor will do a load bank test on an</p>		

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	<p>2. Based on record review and interview, the facility failed to ensure a complete written record of weekly inspections of the starting batteries for the emergency generator was maintained for 12 of 52 weeks. Chapter 3-4.4.1.3 of NFPA 99 requires storage batteries used in connection with essential electrical systems shall be inspected at intervals of not more than 7 days and shall be maintained in full compliance with manufacturer's specifications. Defective batteries shall be repaired or replaced immediately upon discovery of defects. Furthermore, NFPA 110, 6-3.6 requires checking storage batteries, including electrolyte levels, at intervals of not more than 7 days. Chapter 3-5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Generator Load Testing Log Sheet: Weekly Exercise" documentation with the Plant Operations Director during record review from 9:30 a.m. to 11:35 a.m. on 08/26/11, weekly emergency generator records for the forty</p>				<p>annual basis. IV. The weekly audits of the emergency generator and the annual inspections from the outside contractor are reported to the facility's quality assurance committee monthly for additional recommendations and to ensure continued compliance.</p>		

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	<p>week period from 11/16/10 through 08/23/11 was maintained, but no documentation of weekly starting battery inspections prior to 11/16/10 was available for review. Based on interview at the time of record review, the Plant Operations Director stated the facility began operation in May 2010, weekly battery inspections for the emergency generator did not start until 11/16/10, and acknowledged weekly battery inspections prior to 11/16/10 is not available for review.</p> <p>3.1-19(b)</p> <p>3. Based on record review and interview, the facility failed to ensure a monthly load test for 1 of 1 emergency generators was conducted using one of the three following methods: under operating temperature conditions, at not less than 30% of the Emergency Power Supply (EPS) nameplate rating, or loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of generators serving the emergency electrical system to be in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the</p>						

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	<p>following methods:</p> <p>a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating.</p> <p>b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer.</p> <p>The date and time of day for required testing shall be decided by the owner, based on facility operations. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Generator Load Testing Log Sheet: Weekly Exercise" documentation with the Plant Operations Director during record review from 9:30 a.m. to 11:35 a.m. on 08/26/11, the emergency generator ran on a monthly basis for at least thirty minutes each month for the period of 11/16/10 through 07/26/11 but the minimum exhaust gas temperature and operating temperature are not recorded, however, the percentage of load capacity was recorded as 6% for each month. Based on interview at the time of record review, the Plant Operations Director stated the minimum exhaust gas temperature and operating temperature are not recorded and acknowledged the percentage of load capacity recorded was less than 30 percent of the EPS nameplate</p>						

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	rating.  3.1-19(b)						